

Letters

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Partnership with patients

Treat patients as you would like to be treated yourself

EDITOR—Patients today are different from patients in the past. Well informed patients want your knowledge, your listening, your analysis, your opinion, but not your decision. Luckily, you need not be the all-knowing doctor of the past. You discuss and reflect and you enable patients to reach a decision on how to face the future. The atmosphere of the consultation should be calm, gentle, and respectful.

If possible, meet patients in the waiting room and invite them into your room. In general, you should encourage them to bring a partner or friend. The discussion may be serious, and at home the partner or friend might help in reconsidering the content of the consultation. Be aware that patients lose their autonomy when visiting a doctor. One of your duties is to try to restore that autonomy.

Always apologise if you are late and therefore in a hurry. If you have not read the notes explain that you have not been able to read the medical notes yet. You will find that then a small miracle happens: patients will

not be dissatisfied but will help you to discover why they are visiting you.

Patients have waited for you. The art of consultation is to devote all your time and attention to them and nothing else. In general, don't take beepers with you and don't answer telephone calls. If a beeper goes off, a telephone call comes through, or someone storms into your room, always ask patients for their permission to deal with these intrusions and promise to make it very short. The time of the consultation is the patients, not yours.

Generally, it is not wise to reach a diagnosis, offer treatment, and come to a decision in the one consultation. Patients need time for reflection and discussion at home.

Consultations are an important part of medical practice. Treat patients as you would like to be treated yourself. Be honest and respectful and make this contact with them a pleasure.

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Local communities have role in influencing health policy

EDITOR—It is heartening to see the *BMJ* follow a recent editorial, which looked at the wider public view of health and the role of local people in creating health,¹ by dedicating an edition to the partnership of doctors and patients.

Coulter's editorial describes the intent to consider the scope for creating meaningful partnerships between doctors and patients and between health policymakers and local communities.² The journal does, however, explore a narrow understanding of patient partnership. Most contributions focus on patients participating in their own care, in clinical decisions about their illness, in the doctor-patient consultation, and in medical research.

This neglects a tradition of work in the United Kingdom to nurture the role of local communities in influencing health policy and in creating and pursuing their own health agenda. This tradition entails a shift from an individual illness based model to a collective model that is concerned with addressing the underlying determinants of ill health. This approach is exemplified by work in west Newcastle over the past five years,³ where the locality group and the

primary care group have funded an independent community development project that is directed by a committee of representatives from the local community. The approach maintains a constant focus on health inequalities and challenges discrimination. Its work with minority groups was recognised last year with the award of an NHS equality award. A recent evaluation of this initiative⁴ showed that the community development approach has been successful in creating and sustaining links with a large number of local community groups and individuals, and important innovations have resulted, as have changes in people's commitment to meeting the needs of minority groups.

Examples of such work, which may be highly valued locally, are often disadvantaged in terms of dissemination because they do not fit into the evidence based framework required for publication in refereed journals. This is partly because it is difficult to define an intervention whose success is often dependent on being responsive, flexible, and adaptable, but also because in a developmental process outcomes cannot be preset.

The renewed interest in community development to be found in *Our Healthier Nation*⁵ and in health action zones suggests as the next step for the *BMJ* an issue dedicated to exploring best practice in this difficult and challenging area.

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1 Fisher B, Neve H, Heritage Z. Community development, user involvement and primary health care. *BMJ* 1999;318: 749-50.

2 Coulter A. Paternalism or partnership? *BMJ* 1999;319: 719-20, (18 September).

3 Freake D, Crowley P, Steiner M, Drinkwater C. Local heroes. *Health Serv J* 1997;107:28-9.

4 Green J. *Community action on health*. Newcastle upon Tyne: Social Welfare Research Unit, University of Northumbria at Newcastle, 1999.

5 Department of Health. *Saving lives: our healthier nation*. London: HMSO, 1999.

Modern antipaternalism needs to be invigorated

EDITOR—With respect to Coulter's editorial, it is sad to see so much reference to user empowerment and antipaternalism¹ without acknowledgement that the passion behind therapeutic communities, social psychiatry, and antipsychiatry has had the same humanitarian and compassionate aim for

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the past 50 years. Thus the idea is not new, although the mode of its expression may be.

Therapeutic communities emerged after wartime experiments in which battle shocked soldiers soon became more effective at helping each other to overcome their neuroses than the doctors and nurses were. David Clarke, at Fulbourne in Cambridge, was one of the first to challenge the idea that doctors had every right to lock up patients for their own convenience, in the movement that became social psychiatry. Ronnie Laing, by detailed descriptions of patients' experience, inspired a generation to believe that there was a different way of conducting themselves with patients. But where is the vision and inspiration from these movements now?

Therapeutic communities are enjoying a resurgence of interest as they stand for one of the few methods of treating personality disorder with good evidence to back it.² Many people with personality disorder are very sensitive to imbalances of power in professional relationships and often strongly react against any degree of paternalism. The relationships they need of professionals are honest, open, and with very clear boundaries. Antipsychiatry survives in a multitude of single issue user groups and a few pioneering projects in the voluntary sector which are trying to deliver meaningful care in the community that is not paternalistic.³ Social psychiatry has not survived, and the overwhelming predominance of psychopharmacological treatments of mental illness leaves us much the poorer. For psychiatry to come in line with Coulter's currents in society, it must incorporate a pluralistic view of human development and give up the idea that "doctor knows best" about human suffering, destructive relationships, and psychological symptoms. We need to learn a deeper respect for patients than diagnosis and care programming allow.⁴

The modern antipaternalism described in the *BMJ* seems like a resurgence rather lacking in libido—rendered joyless and sterile by overmanagement, defensive practice, and political correctness. Only with some of the fervour and inspiration from those earlier days, for bringing humanity into our practice, will it come to life and not be an unwelcome imposition, a managerial device, or a facet of consumerism.

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2 Lees J, Manning N, Rawlings B. *Briefing paper: A systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders*. Nottingham: Nottingham University School of Sociology and Social Policy, 1999. Also available on www.pettarchiv.org.uk/atc-briefingpaper.htm. Full report in preparation.

3 Tucker S, ed. *Dialogue and dwelling: a therapeutic community approach to care in the community*. London: Jessica Kingsley (in press).

4 Campling P, Haigh R, eds. *Therapeutic communities, past present and future*. London: Jessica Kingsley, 1999:11-6.

Doctors in Egypt deal with patients in their own way

EDITOR—Coulter's editorial explained how doctors should regard patients as partners.¹ In Egypt patients often trust their doctors blindly. This is particularly so in the government hospitals, where most of a poor and illiterate population seek medical care. Some time ago a professor at a prestigious educational hospital was saying on Egyptian television that patients should not interfere with their doctors' work and should hand over the responsibility of making decisions to their doctor because patients have not studied medicine. This is the attitude of most doctors in this country—and it is likely to stay that way.

In private practice things look different. Patients are educated, paying customers and consequently much more demanding. Doctors have found ways to combat this menace: acquire an aura of infinite wisdom and philosophical patience; listen for 30 seconds and talk for 10 minutes; pepper speech with incomprehensible medical terms to show off patients' ignorance; talk in imperatives; at any sign of rebellion, look stunned, or, in the case of a professor, look ambivalent. This list is not exhaustive.

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Perspectives must be reconciled

EDITOR—I read with interest Coulter's editorial on partnership with patients.¹ Doctors are arrogant, paternalistic, poor at communication, and steeped in their own values. Patients have unrealistic expectations, make unreasonable demands, are quick to complain, and are unwilling to accept responsibility for their own health.

Reconciling these two perspectives is the challenge of a mature partnership between doctors and patients. Part of the problem is the use of stereotypes. The quality of debate would be improved mightily if it took as its starting point the proposition that we are all made of the same flesh, that we all have our faults (admittedly some more than others), and that we all make mistakes in our dealings with others.

Equally important is the fact that doctors and patients do differ in one crucial respect. Doctors perceive matters relating to illness and health in an entirely different light from their patients. Any doctor will be able to recall the moments during his or her training when he or she realised that not everyone gets better. That realisation is not simply rational; it is emotional. It amounts to a loss of innocence about what medicine can and cannot do. The general public may be intellectually aware of these uncertainties but, with comparatively few exceptions, would prefer to believe that this reflects the limitations of the individual doctor. It is frequently said that doctors fail to communicate. Some of the time, it may be more

accurate to say that the message is one the patient would rather not hear.

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Teamwork is necessary

EDITOR—Partnership with patients, as outlined in Coulter's editorial,¹ is largely an ideal when one is confronted with large numbers of patients in outpatient clinics. It may only be achievable in private practice, where longer consultation times are expected.

The lack of medical consultation time can, however, be overcome by good teamworking. Discussions that I might initiate in the clinic are amplified and often clarified by other team members outside the clinic room. Nurses, dietitians, and social workers all participate in supporting children and their families, especially with conditions such as chronic renal failure. They are often the people who ensure that written and visual information is provided, and we have found great value in home visits so that all family members, including extended family, can be informed.

Making the right decision(s) is the goal, but in modern medical practice it requires a well functioning team to ensure the partnership is a success.

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Family doctors are part of team

EDITOR—I was saddened but not surprised that Watson, in his response to Coulter's editorial on the doctor-patient partnership (above),¹ does not mention the patient's general practitioner (family doctor) in his list of colleagues. I spend a good deal of time interpreting ideas and treatment goals to patients, usually in the context of an ongoing relationship, and often in their home. This relationship is of course facilitated by good communication from (and to) hospital staff, another example of teamworking that is often neglected.

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A little knowledge can be a dangerous thing

EDITOR—With regard to Sculpher et al's editorial, shared decision making with patients needs to be made in the full context of the evidence available, not just the evidence that the patient has brought to the consultation.¹ Limited evidence can bias the decision making process if it is not fairly balanced against all the available evidence on a

particular subject. Two of the examples given in the editorial could lead to conflict in the consultation.

Adopting a mediterranean diet seems much more effective than statins in reducing the risk of cardiovascular disease.^{2,3} Patients and doctors, however, seem obsessed at times at looking at drug treatments in isolation to reduce risk but overlook other interventions that potentially are more effective.

Excessive prescribing of antibiotics can lead to an increasing risk of patients themselves carrying resistant organisms but is in many cases of dubious or no benefit to them.⁴ Increased prescribing has also been associated with high incidence of meningococcal infections within populations.⁵

If patients are made aware of this, they can put their own beliefs and evidence into the context of the whole picture and are better informed, which is less likely to cause confrontation in the consultation. Unfortunately, both doctors and patients are canvassed by reports of effective drug treatments (which earn millions of pounds for drug companies), but other evidence based forms of treatment, which may be inexpensive but more effective, are sometimes ignored. Perhaps we are all biased by promotional evidence—and, of course, all evidence can be biased if taken out of context.

Improved knowledge of evidence will ultimately help doctors, patients, and the healthcare system to approach treatment in a rational and fairer way for all.

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- 2 Keys A, Menotti A, Karvonen MJ, Aravanis C, Blackburn H, Buzina R, Djordjevic BS, et al. The diet and 15 year death rate in the seven countries study. *Am J Epidemiol* 1986; 124:903-15.
- 3 World Health Organisation. *Diet, nutrition, and the prevention of chronic diseases. Report of a WHO study group.* WHO technical report series 797. Geneva: WHO, 1990.
- 4 Arason VA, Kristinsson KG, Sigurdsson JA, Stefansson G, Molstad S, Gudmundsson S. Do antimicrobials increase carriage rate of penicillin resistant pneumococci in children? Cross sectional prevalence study. *BMJ* 1996; 313:387-91.
- 5 Stuart JM, Robinson PM, Cartwright K, Noah ND. Antibiotic prescribing during an outbreak of meningococcal disease. *Epidemiol Infect* 1996;117:103-5.

Hyperbilirubinaemia in term infants

Identifying infants who might benefit from routine measurement of bilirubin during first 48-72 hours of life

EDITOR—The observation reported by Spurgeon of an increased likelihood of readmission with jaundice after earlier neonatal discharge is well made.¹ Lee et al showed that jaundice and dehydration were more severe in newborn infants requiring readmission to hospital after the mean age at discharge fell from 4.5 to 2.7 days,² while Maisels and Kring found a significantly increased risk for readmission with jaundice

among newborn infants discharged from hospital before 72 hours of age.³

In the United Kingdom all newborn infants and mothers can be visited at home regularly by community midwives during the first seven days after discharge. These health professionals are skilled in infant capillary blood sampling and often measure serum bilirubin concentrations as part of their care of mother and infant. The potential clearly exists for possible screening of infants at risk of hyperbilirubinaemia after discharge, but such screening would have to be carefully targeted to avoid an unacceptable increase in workload.

We retrospectively reviewed the case-notes of all infants of ≥ 37 weeks' gestation who had been admitted over three years to the neonatal intensive care unit at an inner city district hospital with clinically significant jaundice (serum bilirubin $> 340 \mu\text{mol/l}$). Altogether 21 such patients were admitted (mean age 83.5 hours; mean serum bilirubin concentration $415.3 \mu\text{mol/l}$ (range 340-768)). Eleven were admitted from postnatal wards and 10 from the community. The diagnosis was glucose 6-phosphate dehydrogenase deficiency in three cases, ABO incompatibility in 10, physiological (including breast milk) jaundice in six, cephalhaematoma in one, and the Crigler-Najar syndrome in one. One infant was white, nine were Asian, and 10 African or Caribbean; one infant was of mixed Asian and Caribbean parentage.

The mean age at admission of infants from the postnatal wards was 59.8 hours and from the community 109.5 hours (two sample unpaired *t* test, $P = 0.0004$). Mean serum bilirubin concentration was $396.6 \mu\text{mol/l}$ (range 340-479) and $435.9 \mu\text{mol/l}$ (range 354-768) respectively. Of the 11 infants from the postnatal wards, eight had ABO incompatibility, two physiological jaundice, and one cephalhaematoma. Of the 10 from the community, three had glucose 6-phosphate dehydrogenase deficiency, two ABO incompatibility, four physiological jaundice, and one the Crigler-Najar syndrome.

Although based on small numbers, our survey shows that infants who might benefit from routine measurement of serum bilirubin concentration during the first 48-72 hours of life include those of Asian and African or Caribbean ethnic groups and those from groups with a high prevalence of glucose 6-phosphate deficiency. This may result in the earlier detection of clinically significant neonatal jaundice in most cases.

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- 2 Lee KS, Perlman M, Ballantyne M, Elliott I, To T. Association between duration of neonatal stay and readmission rate. *J Pediatr* 1995;127:758-66.
- 3 Maisels MJ, Kring E. Length of stay, jaundice and hospital readmission. *Pediatrics* 1998;101:995-8.

Hyperbilirubinaemia is a marker for inadequate breast feeding

EDITOR—The study reported by Spurgeon found that the most common reason for neonatal readmission was hyperbilirubinaemia and that readmission rates had increased since hospital stay after delivery had decreased.¹ Perhaps this reflects a lack of community health services and support for new mothers. In the United States women are often discharged to little or no help at home. Their husband (if they have one) or their mother might be able to take a week off work to help, but that is all. They might receive one visit from a nurse during the first week. This is not enough. Other cultures offer months of support after delivery. This support can come from female relatives (as in Sierra Leone) or healthcare professionals (Plunkett nurses in New Zealand).

New mothers who lack support are prone to postpartum sadness and problems with breast feeding. Hyperbilirubinaemia is a marker for inadequate breastfeeding.^{2,3} There may be nothing wrong with sending women home early from hospital, so long as they have help at home from the community until breast feeding is well established and their confidence is strong.

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- 2 DeCarvalho M, Klaus M, Merkat R. Frequency of breast-feeding and serum bilirubin concentration. *Am Dis Child* 1982;136:737-8.
- 3 Yamauchi Y, Yamanouchi I. Breast-feeding frequency during the first 24 hours after birth in full-term neonates. *Pediatrics* 1990;86:171-5.

Intervention for late life depression in residential care

Being old, depressed, and disabled is to be in triple jeopardy

EDITOR—Llewellyn-Jones et al have provided strong evidence that a multifactorial intervention for late life depressive illness has a measurable beneficial effect.¹ I have provided specialist medical services to the community that Llewellyn-Jones et al studied and as a researcher have tried to study similar participants in clinical trials of multifactorial interventions. Research into rehabilitation, falls, and geriatric evaluation and management share the same issues as depression.

Haynes (in his editorial accompanying the paper)² and Deeks and Juszczak (in their commentary)³—and the rapid responses to the paper⁴—raise important issues. Although this area of clinical investigation remains in development, it is clinically relevant research. The researchers did well to follow up the percentage of participants that they did. The number eligible was 220, and they managed to have outcomes for 185 (85%). This included 15 participants who died: death is a legitimate end point for the frail older people studied.

The study showed an improvement of about 2 points on the 30 item geriatric depression scale. Is this worthwhile? As a clinician I vote yes. Remember that this is the real world of care of older people, with limited resources and hard pressed nursing staff, personal care staff, and general practitioners. If the intervention works in Llewellyn-Jones et al's large and architecturally outdated facility in Sydney it will be even more effective in well resourced retirement communities. In the United Kingdom the structure of general practice (which encourages closer medical supervision of frail older people) should also improve the effectiveness of the intervention.

The intervention has components that should be available to all older people as a right. Callahan argues for a basic humane health service as a minimum for all older people.⁴ The intervention falls into this league. Cost effectiveness analyses are unlikely to support the types of programmes pioneered by Llewellyn-Jones et al unless they reduce the need for admission to hospital or increased help with activities of daily living. Because admission to hospital with depressive illness is uncommon in the population studied and most participants already required some help with activities of daily living, sample sizes for a cost effectiveness study are likely to be large. In a population with a genuine unmet health need it is almost axiomatic that it will cost more to meet this need.

Evidence based health care seems to be better accepted if the evidence supports a lower cost intervention. If the evidence supports the efficacy of a more costly intervention healthcare managers and planners seem less interested.

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- 2 Haynes B. Can it work? Does it work? Is it worth it? *BMJ* 1999;319:652-3. (11 September.)
- 3 Electronic responses. Multifaceted shared care intervention for late life depression in residential care: randomised controlled trial. *eBMJ* 1999;319. (www.bmj.com/cgi/eletters/319/7211/676 (accessed 21 December 1999).)
- 4 Callahan D. *Setting limits: medical goals in an aging society*. New York: Simon and Schuster, 1987.

Important research seems to have been greeted with only two faint cheers

EDITOR—I read the paper by Llewellyn-Jones et al on multifaceted shared care intervention for late life depression in residential care,¹ together with Haynes's accompanying editorial² and the commentary by Deeks and Juszcak.¹ I was left with the impression that this important piece of research had been greeted with two faint cheers rather than the three heartier ones it probably deserved.

Neither the editorial nor the commentary makes the important points that, firstly, depression among elderly people is common,

underdetected, undertreated, and an appreciable public health problem; secondly, depression among elderly people in residential care is extremely common, grossly underdetected, and grossly undertreated and seems to have an appalling prognosis³; and, thirdly, because the aetiology of such late life depressions is usually multifactorial we need to evaluate multipronged interventions among large populations.

It is difficult to do good quality research on depression in residential care, and the editorial and the commentary on the paper emphasise this. Although the design of Llewellyn-Jones et al's study can be criticised, it would seem virtually impossible to mount both arms of such a trial simultaneously within one large residential institution.

The variability that would be produced by using two or more institutions would probably outweigh the temporal variability introduced by Llewellyn-Jones et al's methodology. Even modest improvements in depression scores and modest changes in general practitioners' behaviour may have considerable impacts on overall population morbidity from depression. A small decrease in alcohol use in a community is associated with a considerable benefit to some individuals at risk, and the same may be true of small improvements in depression scores.

Finally, it seems unfair for Haynes to criticise the dropout rates in the study. If you are going to do research with very old people some of them are going to die and any intervention which prevented that would certainly be worth a headline.

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- 2 Haynes B. Can it work? Does it work? Is it worth it? *BMJ* 1999;319:652-3. (11 September.)
- 3 Ames D. Depressive disorders among elderly people in long-term institutional care. *Aust NZ J Psychiatry* 1993;27:379-91.

How much trial and error should we tolerate in community trials?

EDITOR—Haynes's editorial¹ refers to a trial by Llewellyn-Jones et al in which the modest result is attributed to a variable degree of programme implementation.² Haynes assures us that trial and error is a necessary part of the evolution of trials. This ignores the broader question of how much effort we should devote to getting an intervention right before we put it to the ultimate test (the randomised controlled trial)—particularly ambitious interventions that set out to "change the care culture."²

When we depart from the tidy world of drug trials to the murky world of community trials, where do we draw the line between efficacy and effectiveness? If we are too ready to accept the "real world" conditions of effectiveness trials we may risk a prolifera-

tion of state of the art evaluations of far less than state of the art interventions. This prospect seems extremely wasteful.

These issues are felt acutely in health promotion, where some spectacular failures have led to intensive soul searching about the differences between programme failure and evaluation failure and, in the event of programme failure, whether this is accounted for by implementation failure or theory failure. A randomised controlled trial is an unnecessarily expensive way of learning about implementation failure. This has led to the view that a cycle of implementation and review, of getting the implementation as right as feasibly possible, should precede the evaluation of programme outcomes. In other words, randomised controlled trials should have starting rules as well as stopping rules.

Haynes argues that we are only learning to run with community trials. This may be the case, but we are certainly not just learning to run with community interventions. Nor are we ignorant of methods to assess contextual factors in programme environments,³ or methods to guide change processes,⁴ or methods to assess implementation.⁵ This means that we are better equipped than ever to introduce programmes and optimise their functioning before testing.

Undoubtedly, professional judgment is required to determine whether implementation is as right as feasibly possible. What range and type of evidence and skill should be called on? How, for example, might we distinguish naturalistic conditions from poor programme management within a trial? A lot of this has not been assessed because many investigators seem to pay it scant attention. Expert criticism of intervention theory and strategy, as well as scrutiny of the criteria to be used to define intervention integrity, must be part of trial design and review.

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- 3 Moos RH. Assessing the program environment: implications for program evaluation and design. In: Conrad KJ, Roberts-Gray C, eds. *Evaluating program environments. New directions in program evaluation*. San Francisco: Jossey Bass, 1988:7-23. (Jossey Bass higher education and social and behavioral sciences series No 40.)
- 4 Goodman RM, Steckler AB. Mobilising organisations for health enhancement: theories of organisational change. In: Glanz K, Lewis FM, Rimer BK, eds. *Health behavior and health education, theory, research and practice*. San Francisco: Jossey Bass, 1990:314-41.
- 5 Durlak JA. Why program implementation is important. *Journal of Prevention and Intervention in the Community* 1998;17:5-18.

Cochrane preferred to use "effective" where other people used "efficacious"

EDITOR—In his editorial on the testing of healthcare intervention¹ Haynes quoted

definitions of efficacy and effectiveness which he attributed to Archie Cochrane.² Last has made the same attribution for his definition of effectiveness.³

But in referring to the need to apply the randomised controlled trial "to measure the effect of a particular medical action in altering the natural history of a particular disease for the better," Cochrane stated: "It is in this sense that I use the word 'effective' in this book, and I use it in relation to research results, as opposed to the results obtained when a therapy is used in routine practice in a defined community. Some people would like to use the word 'efficacious' for this measurement. This seems reasonable, but as I dislike the word I have not used it here." Hence he used the terminology that is almost exactly the opposite of that attributed to him.

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2 Cochrane AL. *Effectiveness and efficiency: random reflections on health services*. London: Nuffield Provincial Hospitals Trust, 1972.

3 Last JM. *A dictionary of epidemiology*. 3rd ed. Oxford: Oxford University Press, 1995.

Cochrane may not have been first to define efficacy and effectiveness

EDITOR—Haynes credits Archie Cochrane with first defining the terms efficacy, effectiveness, and efficiency as applied to health services.¹ Archie did much to popularise the application of the terms, but they were first promulgated two years earlier at the 14th meeting of the World Health Organisation Expert Committee on Health Statistics in December 1970.²

The late Sir John Brotherston was in the chair and I, as the rapporteur, wrote the report. The concepts and terms, however, came from two other members of the committee: Dr A Sakari Härö (chief of the department of planning, National Board of Health, Helsinki, Finland) and the late Dr Georges Rösch (deputy director of the Centre de Recherches et de Documentation sur la Consommation, Paris, France). The definitions were as follows.

Efficacy: the benefit or utility to the individual of the service, treatment regimen, drug, or preventive or control measure advocated or applied.

Effectiveness: the effect of the activity and the end results, outcomes, or benefits for the population achieved in relation to the stated objectives.

Efficiency: the effects or end results achieved in relation to the effort expended in terms of money, resources, and time.

Any member of our committee could have discussed the terms with Archie, but the most likely candidates are John Brotherston or Dr W P D Logan from the United Kingdom; Dr Logan at that time was the director of the Division of Health Statistics at the World Health Organisation. Alternatively, Archie may have conceived

the terms independently, but unfortunately he did not distinguish clearly between the first two.

Last is correcting the entry for the next (fourth) edition of the *Dictionary of Epidemiology* published by Oxford University Press.

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1 Haynes B. Can it work? Does it work? Is it worth it? *BMJ* 1999;319:652-3. (11 September.)

2 World Health Organisation Expert Committee on Health Statistics. Statistical indicators for the planning and evaluation of public health programmes. *WHO Tech Rep Ser* 1971;472:3-40.

Diagnosing Lyme disease

Support group is needed in the United Kingdom

EDITOR—Wilson, in his personal view on contracting Lyme disease, has shown how difficult it can be in the United Kingdom to secure this diagnosis and receive appropriate advice and support.¹

In August 1996 the *Daily Telegraph* magazine published an article about Lyme disease. At the end of the piece was an offer of a copy of a leaflet on the disease, published by the Association of Medical Microbiologists. Within a month of publication I had received over 900 requests for the leaflet. Most requests were from people whose work or leisure activities put them at potential risk of this infection. Many of them had been unaware of the risk until they read the article.

An appreciable number of requests were also received from patients who told me they, or a close relative, had received a diagnosis of Lyme disease but had been unable to find out anything about the illness. Several reported that their doctor did not believe that this infection existed. There also seemed to be a lot of ignorance among doctors about the availability of diagnostic blood tests.

A frequent theme in the letters I received was the length of time patients had had the symptoms that they attributed to their infection. Accounts of arthralgia, fatigue, malaise, headaches, mood swings, for months or even years after the diagnosis had been made, were common. I was left with the impression that in those fortunate patients in whom the diagnosis had been made and the required antibiotic prescribed, their doctors believed that that was the end of their responsibility. Many patients were left to their own devices to find out about, and cope with, their illness.

I have no special expertise in Lyme disease and I did not write the leaflet I have described. I am the publications secretary of the Association of Medical Microbiologists, and it is my responsibility to distribute the publications of the association to those who ask for them. The text of this leaflet may

be found on the publications page of the association's website (www.amm.co.uk).

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1 Wilson CJF. My years with Lyme disease. *BMJ* 1999; 319:649. (4 September.)

Patients have to learn to help themselves

EDITOR—Judging by the hundreds of calls received at the Lyme Disease Resource Center in northern California, Wilson's experience of not being able to depend on doctors to help him when he contracted Lyme disease is not unusual.¹ Patients with Lyme disease often encounter scepticism and ridicule from the people who are supposed to help them. The doctor's threshold of suspicion is critical. Wilson shows himself to be of the same mindset as those doctors who failed to diagnose his illness when he says that Lyme disease is rare in the United Kingdom. Rare by whose account?

Every endemic area was once "non-endemic," with the possible exception of Lyme, Connecticut—and what we don't look for, we won't find.

There is a new British Lyme Disease Foundation, which maintains a website at www.wadhurst.demon.co.uk/lyme/index.htm.

When we can't depend on the medical profession to help us, we must educate and take care of ourselves.

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1 Wilson CJF. My years with Lyme disease. *BMJ* 1999; 319:649. (4 September.)

All primary care beacons for clinical governance in South West have research funding and fellowship by assessment

EDITOR—The NHS Executive has recently established a process for identifying "beacons of excellence" within the NHS.¹ As members of the regional panel assessing the applications for beacons in primary care in the South West, we were struck by the number of applications from practices that were either actively involved in research and development or contained one or more partners with fellowship by assessment. We therefore analysed the applications, looking at these two indicators.

Of the applications for beacon status, two had research and development funding only, one fellowship by assessment only, and seven both; of successful applications, three had research and development funding only and five both. The table summarises the results.

Unpublished data from the South West have shown that about 3% of practices receive research and development funding (S Gray, personal observation). The proportion of general practitioners with fellow-

Applications to be beacon practices, South West, 1999, showing number of practices with both research and development funding and fellowship by assessment

Area	All applications for beacon status		Successful applications	
	No	No (%) with research funding and fellowship by assessment*	No	No (%) with research funding and fellowship by assessment*
Clinical governance	7	4	4	4
Effective prescribing	6	1	2	0
Patient partnership	6	0	2	0
Information management	4	1	1	0
Health improvement	6	0	3	0
Practice management	5	1	2	1
Clinical services	25	0	1	0
Total	59	7 (12)	15	5 (33)

*Research practices were defined as those receiving either research and development support funding or designated as research and development general practice by NHS Executive Regional Office; practices in process of applying for fellowship by assessment were also included.

ship by assessment is estimated to be less than 1% (Royal College of General Practitioners, unpublished data). All applications for beacon status were peer reviewed at both primary care group level and health authority level before consideration by the regional panel.

The proportion of practices submitted for beacon status with research and development funding (17%) or with partners who were fellows by assessment (14%) was considerably greater than the regional average. Successful applications were substantially more likely than unsuccessful applications to have either one or both of these two markers (8/10 v 7/49, $P < 0.0001$, χ^2 test). All practices that were selected as beacons for clinical governance had both research and development funding and partners who were fellows by assessment.

The relation between involvement in research and development and high quality of care is frequently asserted, and there is some limited evidence to support the claim.² The finding that over half of the beacon practices selected in the South West currently receive research and development funding suggests that engagement in research and development is likely to be associated with high quality clinical services, although it does not provide any evidence of cause and effect.

Alternative explanations could include the fact that any independent external accreditation substantially increases the chance of beacon status or that practices have been "trained" to complete application forms by applying for research and development funding and fellowship by assessment. While both of these facts may contribute, we think it is highly unlikely that they explain the association between involvement in research and development or fellowship by assessment and an independent peer review assessment of quality.

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1 Department of Health. *NHS beacon services*. London: DoH, 1999. (Health service circular 1999/034.)

2 Chen J, Radford M, Wang Y, Marciniak T, Krumholz H. Do "America's best hospitals" perform better for acute myocardial infarction? *N Engl J Med* 1999;340:286-92.

Eighth principle in reconfiguring acute hospital services

EDITOR—Smith describes the seven principles that should be followed when reconfiguring acute hospital services.¹

There is an eighth principle, most important of all for economy—that no condition manageable in a spoke should ever progress to or remain in a hub. This entails bottom up rather than top down planning. Ninety per cent of all contacts are handled in primary care and 50% of inpatients and 90% of "casualties" can be managed in minor injury units. Trauma centres and super-specialist units are the way ahead for a minority of patients. The majority must be prevented at all costs (sic) from entering them.

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1 Smith R. Reconfiguring acute hospital services. *BMJ* 1999; 319:797-8. (26 September.)

Don't compensate less efficient teaching hospitals, redistribute clinical medical students

EDITOR—Bevan delivers a refreshing critique of the allocations paid by the service increment for teaching (SIFT), which ostensibly are aimed at compensating healthcare organisations for the excess service costs resulting from the teaching of undergraduate clinical medical students.¹

In response to the introduction of the internal market we carried out empirical research into the size and distribution of the direct costs to the NHS of teaching medical students from Leicester University Medical School.² This included a student diary study with a 97% response rate, from which we

could estimate the cost of time spent teaching medical students by all NHS funded staff in all settings.³ One of the main findings was the comparatively low costs of teaching (about £700 000 (\$1.2m)) compared with the size of the total SIFT allocation (over £11m) for these students. Even when taking into account the excess costs of NHS libraries, the capital costs of rooms for teaching students, and the costs associated with the increased probability of consultants from teaching hospitals receiving merit awards, the SIFT allocation seemed to be clearly in excess of the associated NHS costs. There is also little evidence in England of a more complex case mix, attributable to the presence of medical students, which could account for the shortfall.⁴

The Leicester study suggests that the absolute allocation per student may be far in excess of the actual attributable excess service costs, thus giving an unfair subsidy to teaching hospitals. The large variations in the estimated excess costs between medical schools and associated hospitals across the country indicate that there are noticeable variations in the efficiency with which clinical medical students are taught in NHS hospitals. Rather than compensating the more expensive teaching hospitals for (possibly) unnecessary costs we should consider ways of redistributing medical students to those medical schools, teaching hospitals, and teaching settings in the community that have the lowest marginal excess costs.⁵

The NHS is being urged to focus its spending on more cost effective interventions and those that will be effective in reducing inequalities. Given the ad hoc way in which over £400m is allocated, with little regard to efficiency or equity, and the recent decision to increase the numbers of medical students, both the size and the distribution of SIFT payments need urgent critical examination by a body independent of those vested interests that benefit most from the current arrangements. Surely, it is time for the National Audit Office to investigate.

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1 Bevan G. The medical service increment for teaching (SIFT): a £400m anachronism for the English NHS? *BMJ* 1999;319:908-11. (2 October.)

2 Sheldon TA. *The Leicester University study of undergraduate clinical teaching*. Leicester: Trent Regional Health Authority and Leicester University, 1990.

3 Sheldon TA, Clarke M, Woods J. The student diary survey: a method of monitoring hospital-based medical education. *Med Educ* 1991;25:213-3.

4 Rayner M. *Teaching and non-teaching hospitals: case and activity comparisons*. London: DHSS Operations Research Service 1985. (ORZ1159/2.)

5 Sheldon TA. The NHS review and the funding of teaching hospitals. *Management in Medicine* 1991;5:6-17.

Rapid responses



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